Region: XX, Regional Supervisor's Name **Facility: Your Nursing Facility**

Illinois Department of Public Aid
Bureau of Long Term Care
Medicaid Resident Vaccine Administrative Record

Last	First	RIN	Date	Initials
Doe	Jane01	345678912	____/____/ 2004	_____
Doe	Jane02	345678912	____/____/ 2004	_____
Doe	Jane03	456789123	____/____/ 2004	_____
Doe	Jane04	567891234	____/____/ 2004	_____
Doe	Jane05	678912345	____/____/ 2004	_____
Doe	Jane06	789123456	____/____/ 2004	_____
Doe				
Doe				
Doe				
Doe				
Doe				
Doe	Jane12	512346789	____/____/ 2004	_____
Doe	Jane13	612345789	____/____/ 2004	_____
Doe	John01	123456789	____/____/ 2004	_____
Doe	John02	234567891	____/____/ 2004	_____
Doe	John03	912345678	____/____/ 2004	_____
Doe	John04	112345678	____/____/ 2004	_____
Doe	John05	223456789	____/____/ 2004	_____
Doe	John06	712345689	____/____/ 2004	_____
Doe	John07	812345679	____/____/ 2004	_____

Number of Residents in your facility: 20

I,_____, representing said facility, hereby certify the 2004-2005 shipment of influenza vaccine, provided by the Illinois Department of Public Aid, has been administered to the Medicaid eligible residents listed in this document.

_____
Administrator

_____
Date